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MEDICAL POLICY – 8.03.09

Vertebral Axial Decompression

BCBSA Ref. Policy:	8.03.09	
Effective Date:	July 1, 2024	RELATED MEDICAL POLICIES:
Last Revised:	June 24, 2024	8.03.501 Chiropractic and Other Manipulation Services
Replaces:	N/A	

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

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Introduction

Vertebral axial decompression is a type of traction for the low back. The idea is to stretch the spine. This stretching is intended to create more space between the bones of the spine (the vertebrae) to relieve pressure on damaged discs. The goal is to relieve low back pain caused by damaged discs or other problems with the vertebrae or tissues. This service is investigational. There are not enough high-quality published medical studies to determine whether this treatment is effective.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Procedure	Investigational
Vertebral axial decompression	**Vertebral axial decompression is considered investigational.**

Coding

Code	Description
HCPCS	
S9090	Vertebral axial decompression, per session

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

N/A

Evidence Review

Description

Vertebral axial decompression applies traction to the vertebral column to reduce intradiscal pressure and, in doing so, potentially relieves low back pain associated with herniated lumbar discs or degenerative lumbar disc disease.

Background

Vertebral axial decompression (also referred to as mechanized spinal distraction therapy) is used as traction therapy to treat chronic low back pain. Specific devices that are available are described in the **Regulatory Status** section.

In general, during treatment, an individual wears a pelvic harness and lies prone on a specially equipped table. The table is slowly extended, and a distraction force is applied via the pelvic harness until the desired tension is reached, followed by a gradual decrease of the tension. The cyclic nature of the treatment allows the individual to withstand stronger distraction forces compared with static lumbar traction techniques. An individual session typically includes 15 cycles of tension, and 10 to 15 daily treatments may be administered.

Summary of Evidence

For individuals with chronic lumbar pain who receive vertebral axial decompression, the evidence includes two systematic reviews and randomized controlled trials (RCTs). Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Evidence for the efficacy of vertebral axial decompression on health outcomes is limited. Because a placebo effect may be expected with any treatment that has pain relief as the principal outcome, RCTs with sham controls and validated outcome measures are required. The only sham-controlled randomized trial published to date did not show a benefit of vertebral axial decompression compared with the control group. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Ongoing and Unpublished Clinical Trials

A search of **ClinicalTrials.gov** in February 2024 did not identify any ongoing or unpublished trials that would likely influence this policy.

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

North American Spine Society

The North American Spine Society published guidelines in 2020 on the treatment of low back pain.[5] Their recommendation related to lumbar traction is as follows: "In patients with subacute or chronic low back pain, traction is not recommended to provide clinically significant improvements in pain or function."

Medicare National Coverage

In 1997, Medicare issued a national noncoverage policy (160.16) for vertebral axial decompression.[7]

Regulatory Status

Several devices used for vertebral axial decompression have been cleared for marketing by the US Food and Drug Administration (FDA) through the 510(k) process. Examples of these devices include the VAX-D, Decompression Reduction Stabilization (DRS) System, Accu-SPINA System, DRX-3000, DRX9000, SpineMED Decompression Table, Antalgic-Trak, Lordex Traction Unit, and Triton DTS. According to labeled indications from the FDA, vertebral axial decompression may be used as a treatment modality for individuals with incapacitating low back pain and for decompression of the intervertebral discs and facet joints.

FDA product code: ITH

References

1. Peloza J. Non-Surgical Treatments for Lower Back Pain. Spine-health. **https://www.spine-health.com/conditions/lower-back-pain/non-surgical-treatments-lower-back-pain**. Updated April 20, 2017. Accessed May 15, 2024.
2. Vanti C, Turone L, Panizzolo A, et al. Vertical traction for lumbar radiculopathy: a systematic review. Arch Physiother. Mar 15 2021; 11(1): 7. PMID 33715638
3. Wang W, Long F, Wu X, et al. Clinical Efficacy of Mechanical Traction as Physical Therapy for Lumbar Disc Herniation: A Meta-Analysis. Comput Math Methods Med. 2022; 2022: 5670303. PMID 35774300
4. Schimmel JJ, de Kleuver M, Horsting PP, et al. No effect of traction in patients with low back pain: a single centre, single blind, randomized controlled trial of Intervertebral Differential Dynamics Therapy. Eur Spine J. Dec 2009; 18(12): 1843-50. PMID 19484433
5. North American Spine Society. Evidence-based clinical guidelines for multidisciplinary spine care: diagnosis & treatment of low back pain. 2020. **https://www.spine.org/Portals/0/assets/downloads/ResearchClinicalCare/Guidelines/LowBackPain.pdf**. Accessed May 15, 2024.
6. Centers for Medicare & Medicaid Services. National Coverage Decision (NCD) for Vertebral Axial Decompression (VAX-D) (160.16). 1997; **https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?ncdid=124**. Accessed May 15, 2024.

History

Date	Comments
11/11/97	Add to Therapy Section - New Policy
09/01/98	Replace policy - Policy updated
11/12/02	Replace policy - Policy reviewed; no change in policy statement
02/10/04	Replace policy - Policy reviewed; no change in policy statement.
05/10/05	Replace policy - Policy reviewed; no change in policy statement.
03/14/06	Replace policy - Policy reviewed with literature search; no change in policy statement. VAX-D added to title.
10/09/07	Replace policy - Policy updated with literature review; no change in policy statement. Reference update and addition.
10/14/08	Replace policy - Policy updated with literature search; no change to the policy statement. References added.
12/08/09	Replace policy - Policy updated with literature search; no change to the policy statement.
12/14/10	Replace policy - Policy updated with literature search; reference 9 added; policy statement unchanged.
11/10/11	Replace policy – Policy updated with literature search through August 2011; policy statement unchanged.

Date	Comments
12/19/12	Replace policy. Policy updated with literature search through August 2012; references reordered; policy statement unchanged.
12/09/13	Replace policy. Policy reviewed. Policy Guidelines reformatted for readability. A literature search through August 22, 2013 did not prompt a revision of the references. Policy statement unchanged. CPT code 97012 removed; it is not specific to this policy.
01/21/14	Update Related Policies. Add 7.01.551.
12/17/14	Annual Review. Policy updated with literature review through September 15, 2014; policy statement unchanged. ICD-10 diagnosis and procedure codes removed; these do not relate to policy adjudication.
12/08/15	Annual Review. No change to policy statement. No references added.
06/01/16	Annual Review, approved May 10, 2016. Policy reviewed. A literature search through April 28, 2016 did not prompt a revision of the references. No change to the policy statement.
07/01/17	Annual Review, approved on June 6, 2017. Policy updated with literature review through March 27, 2017; reference 2 added. Policy statement unchanged.
07/01/18	Annual Review, approved June 22, 2018. Policy updated with literature review through February 2018; no references added. Policy statement unchanged.
07/01/19	Annual Review, approved June 4, 2019. Policy updated with literature review through February 2019; 2 references removed; no references added. Policy statement unchanged.
07/01/20	Annual Review, approved June 4, 2020. Policy updated with literature review through February 2020; References added. Policy statement unchanged.
07/01/21	Annual Review, approved June 1, 2021. Policy updated with literature review through March 1, 2021; no references added. Policy statement unchanged.
07/01/22	Annual Review, approved June 13, 2022. Policy updated with literature review through February 23, 2022; reference added. Policy statement unchanged.
02/01/23	Update Related Policies. 8.03.501 – title changed from “Chiropractic Services” to “Chiropractic and Other Manipulation Services”
07/01/23	Annual Review, approved June 26, 2023. Policy updated with literature review through February 27, 2023; references added. Policy statement unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization.
07/01/24	Annual Review, approved June 24, 2024. Policy updated with literature review through February 15, 2024; no references added. Policy statement unchanged.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review

and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.